Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARCUS P HAYES
PO BOX 198
BARKER TX 77413

Respondent Name
CITY OF SAN ANTONIO

Carrier's Austin Representative Box
Number 19

MFDR Tracking Number
M4-12-3280-01

MFDR Date Received
July 5, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…Specific provisions contained in the Labor Code…shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicare Services (CMS) in administering the Medicare program…The procedure code 97750-FC, falls into this exception. An FCE is billed and reimbursed in accordance with 28 Texas Admin Code 134.203(c)(1); however, an FCE is a Division-specific code with a Division-specific modifier (97750-FC) defined as a comprehensive evaluation focusing on measuring the patient's functional abilities (potential for work). CPT code 97750 (physical performance tests/measurements) is classified as an 'always therapy' code …***Therefore, the FCE is not subject to the Medicare payment provision of a multiple procedure payment reduction for selected therapy services.*** Therefore, AI&FATC requests VIA Metropolitan Transit to remit the balance due of $32.97."

Amount in Dispute: $32.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 27, 2012	CPT Code 97750-FC DWC conversion factor of $54.86 divided by Medicare conversion factor of $34.0376 x participating amount of $30.73 = $49.53 x 8 units billed = $396.24 (MAR) minus respondent's previous payment of $363.27 = $32.97.	$ 32.97	$32.97

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the

procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.204 sets forth the medical fee guideline for specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanations of benefits (EOB)
   - 59J – processed based on multiple or concurrent procedure rules. Practice expense component for select therapy services reduced by 25% for non-facility and 25% for facility
   - 18 - duplicate claim/service

Issues

1. Did the respondent support denial reason '59J'?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent reduced the payment of the disputed service based on denial reason "59J - Processed based on multiple or concurrent procedure rules, *practice expense component for select therapy services reduced by 20% for non-facility and 25% for facility.*" 28 Texas Administrative Code §134.204 (a)(5) states "Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program…" The procedure code in dispute, 97750-FC, falls into this exception. The '59J' denial reason is not supported. This review will be in accordance to the applicable Division rules and fee guidelines.

   28 Texas Administrative Code §134.204 (g) states, "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c) (1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. The submitted documentation is reviewed. The requestor billed 8 units. The FCE report states time in/time out as 08:00-10:15am; therefore, the 8 units are supported.

2. The CMS 1500 indicates this FCE as an interim test. Per §134.204(g), an interim test is reimbursed for a maximum of two hours. Additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $32.97.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $32.97 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution	March , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.